State of Nevada
Department of Health and Human Resources
Division of Health Care Financing and Policy

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Division of Health Care Financing and Policy
Request For Information No. ME79
for

MEDICAL HOMES COLLABORATIVE

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This document must be submitted in the vendor's response

See Page 24, for instructions on submitting response.

Contact Information

Company Name _____

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THIS IS A REQUEST FOR INFORMATION (RFI) ONLY AND IS NOT A FORMAL SOLICITATION. NO AWARD WILL RESULT FROM THIS RFI.

Contents

Request for Information process is different from an Invitation to Bid. The State expects vendors to propose creative, competitive solutions to the agency's stated problem or need, as specified below.

1. OVERVIEW OF PROJECT

The Division of Health Care Financing and Policy (DHCFP) is the state agency responsible for the implementation and administration of the Nevada Medicaid Program authorized under Title XIX of the Social Security Act. Medicaid is a federal and state funded assistance program that provides health care coverage to certain low-income and medically vulnerable individuals of all ages. DHCFP is also responsible for administering the Nevada Check Up Program under Title XXI of the Social Security Act, the Children's Health Insurance Program (CHIP).

Fee-For-Service

The fee-for-service (FFS) system is a traditional indemnity health care delivery system in which payment is made to a health care provider after a service is rendered and billed. Providers must be licensed or certified to enter into provider agreement to serve Medicaid recipients. Medicaid recipients in the FFS delivery system are generally free to seek care from any provider, but the providers are not required to accept anyone who presents a Medicaid card. The FFS system is operational in all of Nevada's counties.

There are several utilization review mechanisms in place in the FFS system, including prior authorization for services not routinely covered by Medicaid, for services over normal program limits, pre-admission review and retrospective reviews for certain hospital services, retrospective surveillance utilization review, and drug utilization review.

Full-Risk Managed Care

Temporary Aid to Needy Families/Child Health Assurance Program (TANF/CHAP) recipients in the urban areas of Clark and Washoe counties must currently receive their health care services through a full-risk managed care delivery system. Under the current program, DHCFP contracts with managed care plans (Vendor) licensed by the Nevada Department of Insurance that also meet all DHCFP requirements. Vendors serving the TANF/CHAP population are paid on a per member- per month (PMPM) capitated basis (except for labor and delivery payments). These Vendors assume the risk for all medical benefits and must also provide a number of additional services, including the following:

- Providing or arranging access to medically necessary health services for their members;
- Providing member services and 24-hour nurse advice lines, care management, and care coordination;
- Maintaining a provider network, including adequate and timely reimbursement;
- Assuring quality of care;
- Providing to DHCFP all required reports and documentation of performance; and,
- Participating in annual medical record reviews.

Populations

Nevada's Title XIX Medicaid eligibility can be categorized as two general groups: Temporary Aid to Needy Families/Child Health Assurance Program (TANF/CHAP) and coverage for individuals who are Aged, Blind or Disabled (ABD). While the TANF/CHAP population is comprised of mostly pregnant women and children, the ABD population is comprised of individuals with disabilities and those who are 65 years or older.

Over the past few years, the per member per month cost of providing care for ABD recipients through the fee-for-service system in Nevada has been more than doubled the cost for the TANF/CHAP population. The ABD population is one with complex medical and social needs complicated by chronic diseases and multiple co-morbidities. In addition, this population has a high rate of behavioral health diagnoses and a risk of non-compliance with medications.

DHCFP PCCM Program

A Primary Care-Case Management Program (PCCM) model was operated by DHCFP in the 1980s and 1990s. The program was a voluntary program open to select patients who fell under both the Aged and the Aid to Dependent Children (ADC) categories in Washoe or Clark Counties. It began with the University of Nevada, Reno and University of Nevada, Las Vegas Schools of Medicine before expanding to include other community organizations like NevadaCare and Community Health Centers of Southern Nevada. In addition to the standard FFS system, a per member-per month (PMPM) payment was paid to primary care providers to perform case management services. The payment was based on a combination of factors, including age and county, and for those over 65 years old, whether they were in the community or an institution. When the program ended in 1997, the PMPM ranged from roughly $30 to $140.

Disease Management Program

In 2007, the Nevada State Legislature funded a Disease Management (DM) program in fee-for-service Medicaid to address the needs of these high cost populations. The goals of the DM program were to improve health outcomes and produce a cost savings to DHCFP by coordinating care and reducing duplication of services. The target populations for the program were ABD patients and children utilizing Residential Treatment Centers (RTCs) or other behavioral health services.

APS Healthcare began operating the Disease Management Program in April, 2008. The program consisted of two initiatives:

- Silver State Wellness for the ABD population
- Silver State Kids for the RTC population

However, it soon became apparent that providers needed to play a more central role in case management activities, as there were significant barriers in connecting coordination services with the providers' treatment plans. Moreover, the programs faced a number of challenges including inaccurate patient contact information and a lack of awareness in the community about the programs.

Exploring Other Options

The State of Nevada has joined a nationwide movement in exploring other options to serve these high-cost populations. The Division of Health Care Financing and Policy has consulted with a variety of both national and state resources, in addition to participating in collaborations like the Patient-Centered Primary Care Collaborative and the Washoe County Juvenile Justice medical homes project. On the national level, DHCFP conducted a literature review of related research publications and obtained feedback from the Centers for Medicare and Medicaid Services (CMS), DHCFP vendors, and other state medical home programs, including Indiana, Oklahoma, and Colorado. DHCFP also sought input from Nevada stakeholders such as Federally Qualified Health Centers (FQHCs), the State Health Division and the Nevada Health Care Coalition. There are generally four major approaches to coordinating the care of high cost populations:

- **Patient Centered Medical Home (PC-MH)** – This builds upon the original Primary Care-Case Management concept and was most recently defined in the Joint Principles for Patient Centered Medical Home. A physician, or in some states, a nurse practitioner, is responsible for coordinating most aspects of a patient's care and receives additional compensation for doing so. The benefit to this model is that physicians already have the medical skills, expertise, and patient relationships to coordinate care. Potential challenges include a provider's lack of time and resources to coordinate care and limited knowledge about community resources.

- **Administrative Services Organization (ASO)** - This model is where the State contracts with an outside vendor to perform case management services. The benefit to this model is that ASOs generally have vast experience in providing successful case management services. Potential challenges include maintaining communication and collaboration with the providers who are actually developing the treatment plans and providing care.

- **Networks and/or Accountable Care Organizations (ACO)** – Networks and ACOs are similar concepts. Networks are primarily being used in North Carolina, although other states like Colorado are planning to develop similar programs. As a relatively new model that is being done by a few local communities, ACOs contain elements from PCCM, managed care, and ASO models. The ACO model includes hospitals, primary care providers, specialists, and other medical professionals who provide the vast majority of care within their respective networks and are held accountable for patient care and outcomes. They also share PMPM and/or performance-related payments. The benefit to this model is that it would encompass a wide range of health care providers, potentially having the most effect on health outcomes and expenditures. A potential challenge includes identifying enough providers who would be interested in participating in local networks. Moreover, the newness of this model means that more time is needed to gauge success.

Medical Home Definition

DHCFP is focusing this RFI on the Patient Centered-Medical Homes (PC-MH). However, given the complexities of these types of programs and the number of partners that could be involved, DHCFP is soliciting information on all options. PC-MHs are health care settings that facilitate partnerships between individual patients and their personal physicians. Care is facilitated by health information technology, case management, and other means to assure that patients get the

care they need in a culturally and linguistically appropriate manner. In most states, a medical home is a primary care provider. However, some states have adopted medical homes that include nurse practitioners, behavioral health therapists, or specialists. Whoever is acting as the medical home serves as the manager of the patient's treatment plan by assuming overall responsibility for coordinating all aspects of the patient's care and directing patient activities. They work in conjunction with the patient's other medical providers to support a comprehensive team approach to care coordination.

The goals of a medical home are to expand access to health care, improve health outcomes, increase patient satisfaction with care, reduce expenditures, and decrease duplication of services. The delivery of these goals is centered on the seven Joint Principles for Patient Centered Medical Homes. Developed in 2007 by four major primary care physician groups (American Academy of Pediatrics, American Academy of Family Physicians, American College of Physicians, and American Osteopathic Association), it defines the Patient Centered Medical Homes model as an approach that provides comprehensive primary care to children, youth, and adults in a setting that facilitates partnerships between individual patients and their personal physicians, and when appropriate, the patient's family. The seven principles are:

- ***Personal physician*** - each patient has an ongoing relationship with a personal physician trained to provide first contact, continuous and comprehensive care.

- ***Physician directed medical practice*** – the personal physician leads a team of individuals at the practice level who collectively take responsibility for the ongoing care of patients.

- ***Whole person orientation*** – the personal physician is responsible for providing for all the patient's health care needs or taking responsibility for appropriately arranging care with other qualified professionals. This includes care for all stages of life; acute care; chronic care; preventive services; and end of life care.

- ***Care is coordinated and/or integrated*** across all elements of the complex health care system (e.g., subspecialty care, hospitals, home health agencies, nursing homes) and the patient's community (e.g., family, public and private community-based services). Care is facilitated by registries, information technology, health information exchange and other means to assure that patients get the indicated care when and where they need and want it in a culturally and linguistically appropriate manner.

- ***Quality and safety*** are hallmarks of the medical home:

    - Practices advocate for their patients to support the attainment of optimal, patient-centered outcomes that are defined by a care planning process driven by a compassionate, robust partnership between physicians, patients, and the patient's family.

    - Evidence-based medicine and clinical decision-support tools guide decision making.

    - Physicians in the practice accept accountability for continuous quality improvement through voluntary engagement in performance measurement and improvement.

- Patients actively participate in decision-making and feedback is sought to ensure patients' expectations are being met.

- Information technology is utilized appropriately to support optimal patient care, performance measurement, patient education, and enhanced communication.

- Practices go through a voluntary recognition process by an appropriate non-governmental entity to demonstrate that they have the capabilities to provide patient centered services consistent with the medical home model.

- Patients and families participate in quality improvement activities at the practice level.

- ***Enhanced access*** to care is available through systems such as open scheduling, expanded hours and new options for communication between patients, their personal physician, and practice staff.

- ***Payment*** appropriately recognizes the added value provided to patients who have a patient-centered medical home:

    - It should reflect the value of physician and non-physician staff patient-centered care management work that falls outside of the face-to-face visit.

    - It should pay for services associated with coordination of care both within a given practice and between consultants, ancillary providers, and community resources.

    - It should support adoption and use of health information technology for quality improvement.

    - It should support provision of enhanced communication access such as secure e-mail and telephone consultation.

    - It should recognize the value of physician work associated with remote monitoring of clinical data using technology.

    - It should allow for separate fee-for-service payments for face-to-face visits. (Payments for care management services that fall outside of the face-to-face visit, as described above, should not result in a reduction in the payments for face-to-face visits).

    - It should recognize case mix differences in the patient population being treated within the practice.

    - It should allow physicians to share in savings from reduced hospitalizations associated with physician-guided care management in the office setting.

    - It should allow for additional payments for achieving measureable and continuous quality improvements.

The four physician groups who developed the Joint Principles also worked with the National Committee for Quality Assurance to develop a medical home recognition tool, the Physician

Practice Connections – Patient Centered Medical Home (PPC-PCMH) tool. This tool assesses practices on nine different standards: access and communication; patient tracking and registry functions; care management; patient self-management support; electronic prescribing; test tracking; referral tracking; performance reporting and self improvement; and advanced electronic communications. There are also ten must pass elements within those standards. Practices that choose to undergo the process may be awarded one of three levels of recognition, with reimbursement rates increasing with advancement as a medical home. Information on this tool can be found at www.ncqa.org.

While many states use the Joint Principles as their medical home definition, there is debate among other states that this definition is too narrow and needs to include other providers, like mental health providers. There is also some concern that the PPC-PCMH tool focuses too much on health information technology, which is costly and does not sufficiently account for improving care or clinical outcomes. Those states have developed their own definitions and tools. However, the Joint Principles were amended in February, 2009, to include a footnote that allows states to use nurse practitioners as patient centered medical homes. In addition, both the definition and the tool are the most commonly accepted mechanisms for recognizing medical homes due to the vast knowledge of the organizations involved in developing the tools and the challenges in developing a different or superior process.

Provider Reimbursement Structure

Providers generally do not have the resources needed to fully coordinate care, so most states have developed multifaceted reimbursement systems consisting of fee-for-service payments, monthly per member-per month (PMPM) care coordination fees, and performance-based reimbursements where medical homes are reimbursed for achieving quality and/or cost containment goals.

Common Themes for Success

Most successful medical home programs share common elements beyond the provider-directed team approach to care coordination services. For example, the programs generally began with a multi-year planning process that relied on community partnerships with provider associations, non-profit agencies, employer organizations, other state agencies, and third-party payers. These partners joined together to identify the needs of the community, create a general agreement on the definition of a medical home, and play an active role throughout the life of the program. Pilot projects often stem from this planning process to verify that the program's components are realistic and feasible and that quality improvements and cost reductions can be achieved.

Given most providers' time constraints and caseload capacities, it is often a struggle to provide comprehensive care coordination services. Therefore, financial incentives like PMPM fees and performance-related payments are implemented to assist providers perform these additional duties. Many states also maintain relatively high Medicaid reimbursement rates. Moreover, some states give practice profiles to the individual provider and make some sections of the profile available either to the public or other providers regarding their progress in the program in comparison to all program providers.

Medical home programs appear to have the most impact when they target patients who are at a high-risk for hospitalization in the upcoming year and/or those who have multiple chronic diseases in conjunction with a mental health diagnosis. A team approach consisting of providers, care coordinators, specialists, and the patient help ensure patient commitment and compliance with the program, leading to improved health outcomes and lowered rates of avoidable hospitalizations. Care coordination needs to be viewed as a triangle approach, with the provider, the individual, and the care coordinator all playing equally important roles in the individual's treatment. The patient and/or their family must be active partners in creating treatment plans that they can carry out or the prescribed interventions will not be successful.

Provider availability also contributes to the success of a medical home, such as extended office hours, same-day appointments, and patient hotlines, with email and phone consultations for minor illnesses and face-to-face contact for patients with higher needs. Care coordinators also assist the providers in designing patient health education programs and connecting patients to non-medical resources, like housing and transportation.

The DHCFP Tiered Medical Home Collaborative

The proposed Nevada Medical Homes Collaborative is designed around a framework to place individuals into one of three levels of care based on their current health status:

- Level I – Healthy with minimal medical needs or expenses
- Level II – Chronic diagnose(s) that are relatively managed but are at moderate risk for future hospitalizations and could benefit from some education and preventative services.
- Level III – Chronic diagnoses, multiple co-morbidities, behavioral health issues, high hospital and emergency room utilization, complex medical and social needs and in need of comprehensive case management

This RFI is focused on Level III patients who could most benefit from case management services. Level II patients have been included in DHCFP's Request for Proposal (RFP) for a fiscal agent. Although the intent of this RFI is limited to Level III patients, DHCFP could expand a medical home concept if it proved to be successful. Therefore, DHCFP is interested in all ideas and suggestions related to medical homes.

In order to meet DHCFP's goal of developing a program that will reduce expenditures, DHCFP is exploring options where providers and/or relevant outside vendors (such as vendors that employ care coordinators) would be accountable for quality and cost measures in some kind of partial at-risk arrangement. This means developing a reimbursement system that is at least partially contingent on improved health outcomes and reduced State expenditures.

Reimbursement Structure

Providers and, if applicable, the vendor would receive payments for performing additional duties. The providers would receive both their regular fee-for-service rates and a new per member-per month (PMPM) fee, though a percent could be withheld dependent on their success on a variety of quality and/or cost measures. The overall goal of DHCFP is to identify a reimbursement system that would allow providers to perform additional duties and reward those who provide high-quality and effective care.

DHCFP Options

DHCFP is exploring all possible medical home options. However, four systems have been are of particular interest to Nevada. They are listed below:

- **Participating in a multi-payer collaborative** – There are currently discussions taking place among a broad group of insurers, self-insured employers, and providers that might result in a number of payers adopting medical home programs. If a sizable percent of payers participated, then more of a provider's patients could be eligible to participate, thus providing an additional incentive for practices to join a medical home program. Each health plan or payer would contract with participating providers on individual reimbursement rates, but medical home definitions and other components could be relatively standardized. Practices could then be expected to provide at least some of their own care coordination services using the additional fees paid to them. However, DHCFP could employ practice facilitators who assist the providers transitioning into medical homes.

- **Hiring State-employed care coordinators** – DHCFP could utilize District Office staff or hire additional employees to act as care coordinators. They would work with providers on treatment plans and referrals.

- **Contracting with an Administrative Services Organization or Managed Care Organization**– An outside vendor could provide care coordination and case management services. They would have to develop mechanisms for maintaining communication and collaboration with providers.

- **Developing network pilot projects** - Regional networks could be developed consisting of primary care providers, hospitals, specialists, therapists, care coordinators, and/or other providers who share specific resources, like case management staff, information technology, and a regional coordinator. Each network would have a governing body representative of patients and providers. Both the networks and the medical homes would receive PMPM reimbursements for providing these services. Regional networks would be accountable for achieving cost, health, utilization, satisfaction, and access goals.

2. SCOPE OF WORK

2.1 Purpose

The Division of Health Care Financing and Policy is issuing this Request for Information (RFI) to:

1. Gather input, suggestions, and feedback on how Nevada Medicaid can implement a cost effective medical home and care coordination program, specifically for high-needs, high-cost patients;
2. Gauge stakeholder interest in participating in a medical homes program; and,
3. Receive feedback that could be used to develop a Request for Proposal (RFP).

DHCFP seeks to promote a client-centered, outcomes-focused system of care that affordably maximizes the health, functioning and self-sufficiency of clients.

This RFI is not a solicitation for products and/or services and will not result in an award or contract. However, the information collected from this RFI will be used to refine DHCFP's medical home model and to guide in the drafting of any resulting Requests for Proposals (RFPs).

DHCFP encourages anyone with an interest in the medical home model to respond. Interested providers (individual physicians, physician practices or clinics), hospital systems, clients, community and statewide social service organizations, local governments, managed care organizations, health plans, quality organizations, health foundations and any other interested party are encouraged to respond. DHCFP is interested in receiving solutions that showcase both value and innovation. Information submitted by an interested party is voluntary and with the understanding that this RFI is for information gathering purposes only and is not a formal solicitation.

2.2 Inquiries

The Inquiries section is broken into sections that are targeted to specific identified groups or persons. This division was made for the convenience of responders who otherwise might find the RFI too daunting, but who might be willing to spend the time to answer a smaller fraction of the total. However, responders are not limited to answering only the questions posed directly to them. Any responder is free to answer any or all questions regardless of their sectional placement. In addition, the last section of the RFI seeks input from all responders.

DHCFP reserves the right to disclose the information submitted in response to this RFI to Department and State employees, and some or all of the information may be posted publicly.

Basic Questions

In order to efficiently compile all the feedback expected to this RFI, please answer the following questions to help us sort and group respondents and their answers together.

1. Please choose the best description of your or your organization:
   - Medical provider
   - Provider advocate or association (e.g. medical society)
   - Client
   - Client advocate
   - Health plan or payer
   - Foundation
   - Another public or private program
   - Legislator
   - Other (please describe)

2. What is your overall impression of the medical home program?
   - Very favorable
   - Favorable

Neutral
Unfavorable
Very unfavorable

3. What is the likelihood that you will seek to participate in the program?
Very likely
Likely
Reserved (waiting to see the RFP)
Unlikely without significant changes
Will not seek to participate

Questions for Recipients/Recipient Advocates

DHCFP would like a coordinated system of client care including medical, oral, behavioral and social care, using a whole-person approach.

1. Please identify yourself or your organization. What is your current relationship with the Medicaid program?

2. Would you be interested in participating in the medical home model?

3. What services should a medical home be required to perform or participate in (i.e. disease-specific trainings, extended office hours, knowledge of community resources, etc.)? Why are these services important in a medical home?

4. How can a provider best address all of the patients' needs (i.e. medically, socially, etc.)?

5. What experience do you have with vendors that have successfully supported aged and/or disabled populations? What components of their programs contributed to their success?

6. What should be the job functions of the care coordinator? What types of medical and social services should care coordinators have knowledge of? How should the provider and the care coordinators work together?

7. What would be the best method for ensuring communication and collaboration between care coordinators and providers (i.e. weekly/monthly care coordination meetings, shared access to electronic files, onsite case manager, establishing one day a week where those patients visit their medical homes in conjunction with their care coordinator, etc.)?

8. What would be the best method for ensuring communication between care coordinators and the patients (i.e. regularly scheduled phone calls, visiting patients at home, accompanying them on doctors' visits, working from the doctors' office, etc.)?

9. It can be a challenge to change patient behavior. What mechanisms should be put into place to facilitate patient involvement and commitment to treatment plans?

10. What are the key program requirements for you and/or your clients?

11. What kind of special tests or assessments, such as special developmental, functional or cognitive exams, would you like the medical homes and/or care coordinators to be able to perform?

12. Please propose health, healthcare, satisfaction, and access performance measurements for DHCFP's consideration to be used to measure the success of the program.

13. How could the internet be used in a medical home program (i.e. provider websites for making appointments, coordinating treatment plans, emergency room providers scheduling follow-up appointments for patients, etc.)? Would physician, hospital, pharmacists, or other health professionals' websites be helpful tools? If so, what information should those websites contain?

14. Do you have other feedback that you would like to share about the medical homes model?

Questions for Primary Care Providers and Associations

1. Please provide your name, location, area of practice and specialty. What is your current relationship with the Medicaid program? Do you currently participate in any managed care?

2. What definition should DHCFP use for a medical home (i.e. Joint Principles or something else)? What kinds of providers should qualify as a medical home?

3. How should DHCFP recognize different tiers of medical homes (i.e. should DHCFP use the Physician Practice Connections – Patient Centered Medical Home tool or something else)?

4. Would you be interested in participating as a medical home? What components are necessary of a medical home for patients dealing with chronic poverty and health issues? What specific accommodations would you be willing to make to assist in achieving positive health outcomes (i.e. flexible scheduling, coordinating appointments with other providers, etc.)?

5. How can DHCFP assist practices implement the infrastructure needed to be a medical home (i.e. provide practice facilitators to help with implementation, conduct webinars or trainings, assist with HIT, etc.)?

6. Would a care coordinator be a helpful tool for your practice or would it create unnecessary work? What role should they play in your practice and treatment planning? How would they be most helpful to you?

7. What would be the best method for ensuring communication and collaboration between care coordinators and providers (i.e. weekly/monthly care coordination meetings, shared access to electronic files, onsite care coordinator, etc.)?

8. DHCFP recognizes numerous types of providers; much of the care delivered to patients will not be delivered by primary care providers or care coordinators but by pharmacists, home health nurses, county agencies, etc. How could the internet be used to facilitate communication and coordination of care (i.e. establishing provider websites for making appointments, coordinating treatment plans, having emergency room providers schedule follow-up appointments for patients, etc)? Besides the internet, what other communication tools could help in this process?

9. Some states have developed local networks consisting of primary care providers, hospitals, specialists, therapists, care coordinators, and other providers who share resources. They also share responsibility for treatment plans, health outcomes, and PMPM and performance related reimbursements. Is this something you would be interested in participating in? How do you think this could work in Nevada?

10. Would you be willing to expand office hours and/or coordinate with other medical homes to provide after-hours and weekend coverage as a condition of participation? What extra time beyond weekday daytime hours would you be willing to work?

11. Would you be willing to have some same-day appointments reserved for Medicaid clients?

12. What incentives or design would generate the most participation from community providers in a medical home program?

13. How should enrollment occur (i.e. assigned to a medical home based on claims within the past 12 months, given the option when at their doctor appointment, etc.)? Should it be mandatory or optional for patients? Why? Making it mandatory would ensure enough patient involvement but could require a federal waiver or State Plan Amendment. Making it optional would provide more flexibility to patients and could eliminate the need for federal approval, but it could limit program effectiveness due to the time and resources needed to locate patients, secure their participation, and get enough patient involvement to have an overall effect on health outcomes and expenditures.

It has been expressed that unless a provider's practice consists of a high percentage of Medicaid patients, a provider might not be interested in participating in a medical home program. There are currently discussions taking place among a broad group of insurers, self-insured employers, and providers that might result in a number of insurers adopting medical home programs.

14. What percentage of your patients would need to be eligible for the medical home program for you to participate? What percentage of your clients would you be willing to take who are Medicaid clients in a medical home program? How should the

minimal client level be measured (i.e. clients with active care in any 12 month period? Clients who have designated the medical home even if no treatment is sought?)?

15. Would you be willing to participate and agree to the minimal client census requirements if it was part of a medical home incentive program?

DHCFP could invite specialists to become medical homes, especially those who are the primary physicians for clients with chronic specialty conditions. However, there has been some reported unwillingness or inability for a specialist to assume responsibilities for treating the patient's wellness needs or other needs outside the chronic condition. There is the sense that most specialists would prefer to deal only within their specialty and that a primary care physician should deal with all the rest.

16. What role should specialists have in a medical home program? Should specialists have to assume the same whole-person responsibilities that primary care providers assume, or something else? What changes in reimbursement and/or administrative support would create improved access to necessary specialty care? If you are a specialist, what would be necessary to incentivize your participation in the program?

17. Do you use Web-based services currently as part of your practice? If so, how do you use them? If not, how could you use them in the future (i.e. email consultations, appointment setting, etc.)?

18. In what area do you most want support and/or feedback (i.e. HIT, community resources, preventative services, helping patients keep appointments, etc.)?

19. What quality areas are most important to measure to guide performance incentives? What quality measures should DHCFP adopt that might improve health care delivery, or promote good health?

20. What other areas can be addressed that might provide additional cost savings?

21. Would you be willing to accept automated enrollment/direct assignment of new clients to your practice? How many clients would you accept each month?

22. What would be the cost to you to implement this type of program? What changes would you need to make to your practice?

23. What would make the transition to the medical homes program go smoothly for the patients and the practices?

24. Who should be responsible for medication reconciliation and medication management? Is this a core medical home function or one which can and should be delegated to pharmacists?

Questions for Care Coordination Vendors

1. Please provide your organizational name. If you have a parent company or organization, please provide that information as well. What is your current relationship with the Medicaid program?

Central to the medical homes program is accountability for performance. In return for the accountability, DHCFP is considering allowing flexibility in Care Coordination Vendors and rewarding accomplishments with shared savings, additional reimbursements and/or some other incentives. DHCFP seeks to encourage novel delivery systems that promote achievement of performance (for example, supporting community health educators or rewarding community providers for reducing emergency room visits).

DHCFP is considering a set of accountability metrics for health outcomes, risk factor reduction, timely access to care, client satisfaction, reductions in avoidable and preventable health care resource utilization, and per capita cost targets.

The focus of this RFI is high-utilizing, high-cost patients. However, DHCFP serves many eligibility types and recognizes that the goals for differing eligibility types may vary. Expanding the medical home program to include more patients could be considered in the future.

DHCFP is considering using both practice and community level measures as a basis for incentives. DHCFP is evaluating the feasibility of offering the medical homes a base monthly PMPM payment. In addition to this base rate, the medical home might receive more PMPM for providing additional services, meeting outcomes goals, or exceeding measures. (For example, if the participating providers had at least 10 percent of their practice in Medicaid, the PMPM could be slightly larger).

2. What would be suggested percent weightings for accountability for the following categories: 1. timely access to care, 2. health outcomes and risk factor management, 3. client satisfaction, 4. appropriate health care resource and cost management?

3. Please comment on the advisability of requiring HEDIS and/or AHRQ Prevention Quality Indicators (PQIs) compliance. For healthcare resource utilization, DHCFP is considering a target on emergency room utilization, disease specific admission rates (i.e. diabetes, COPD, asthma, etc.), access to preventative health services, follow-up after hospitalization for mental illness, persistence of beta-blocker after a heart attack, other ambulatory sensitive conditions hospitalizations, and/or preference sensitive care variation reduction. Please add other areas and/or comment on the proposed set.

4. DHCFP is considering using some of the above utilization measures to determine a portion of the performance incentives. Many of these are purposefully not practice level measures in order to encourage accountability for the most costly and uncontrolled system costs. What kind of data and support would you be able to offer

the providers to help them manage these extra clinical costs and expenses? Are there other utilization metrics we should consider? How could providers have an impact on these measures?

5. DHCFP recognizes that it will have to have health goals that are appropriate for the need of the patient populations. What specific health and healthy behavior goals are recommended by age, eligibility, and/or disability, especially for the ABD patients?

6. DHCFP is considering requiring a CAHPS survey as its metric for client satisfaction. Please comment. Are there other surveys that would be more applicable to this program?

7. DHCFP is considering access measures such as: (1) time from initial request until appointment, (2) time from appointment to the next follow-up visit, and (4) the time from identification of initial need until a specialty referral appointment is made. Please propose other access metrics and comment on the ones proposed.

8. DHCFP believes that dual eligible clients may need additional and/or different quality incentives. Long-term care services are not directly within the scope of the medical home program and cannot be directly managed by the medical home. Are Skilled Nursing Facility bed day reduction and transition of care between settings appropriate measures given the inability to directly control these costs? What health and healthcare goals could be adopted for this elderly population?

9. What needs to be changed or remedied with Medicaid processes or procedures before a medical home program is instituted?

10. In what way(s) will the creation of a medical home program create duplication of efforts and how can duplication of efforts and services be avoided?

11. How can DHCFP ensure that all appropriate current effective community-based organizations are appropriately included?

12. If DHCFP should participate in a multi-payer collaborative, how should DHCFP encourage or require participation in multi-payer meetings at the state level to review and adopt evidence-based treatment protocols and best practices? Please identify any best practices that should be coordinated across multiple payers.

13. Some concern has been expressed regarding standard approaches to care that either do not work or are too limiting. How should these concerns be addressed?

14. Are there existing coordination or integration efforts already in place or in development that might be impacted by a medical home program? What are these efforts? What measures should DHCFP take to include or account for these efforts in the medical home program design or contracting?

15. What specific medical or non-medical areas should medical homes be responsible for?

16. What capabilities, accreditations or achievements should the medical home have to demonstrate?

17. What kind of case management is realistically achievable in a medical home program? What kinds of case management services, for which clients, would best serve this type of model?

18. What kinds of information should DHCFP gather and provide for web publication?

19. Some states have developed local networks consisting of primary care providers, hospitals, specialists, therapists, care coordinators, and other providers who share resources. They also share responsibility for treatment plans, health outcomes, and performance related reimbursements. These states have been organized into regional entities and require their regional entities to have a part-time paid Medical Director, a Clinical Coordinator, Care Managers and a Pharmacist on staff. DHCFP is considering this model. Would you be able facilitate this process? How could this work in Nevada? How much would this cost? Is there other required staff that should be added to the list?

20. What incentives or design would generate the most participation from providers?

21. If the medical home desired extended hours coverage from the Care Coordination Vendor, in order to fully support the medical home, would you be willing to participate?

22. This population has a high rate of dual physical and behavioral health diagnoses. Are there systematic tried and true ways to ensure that coordination between physical and behavioral health providers happens? How should the Care Coordination Vendor support care management between physical and behavioral health providers for this population?

23. Describe how the Care Coordination Vendors should interact with community stakeholders such as clients/families with special needs, client advocacy groups, community services organizations, etc

24. Share your experience working with caregivers. What activities or characteristics should DHCFP evaluate to identify vendors who have demonstrated a successful collaboration with caregivers?

25. For Care Coordination Vendors, what practices should DHCFP be looking for in regard to reducing ER visits? Which practices should DHCFP expect the medical home to perform in regard to monitoring and reducing ER utilization?

26. What are best practices for reducing in-patient admissions for ambulatory care sensitive conditions such as asthma exacerbation, diabetes or depression?

27. How should the Care Coordination Vendors support the medical homes in avoiding hospital readmissions within 90 days? Who should be responsible for follow-up care after discharge? What are the key elements the Care Coordination Vendors should provide as part of hospital discharge follow-up? Which duties should DHCFP expect the medical homes to perform and which should the Care Coordination Vendors perform, in regard to avoiding hospital readmissions within 90 days?

28. What stratification system should be used to identify those high-utilizing patients most in need of case management services?

29. What components should a pilot project have? Who should be the targeted patients and providers?

30. How long would it take to get this type of model in operation after the start of the contract?

31. What is the maximum number of patients that could be enrolled each month for the first six months of the program?

32. What would you do if you had sufficient technical and financial support and money was not a barrier? What would be the ideal program?

33. Should client self management support (behavior modification and self-efficacy for clients through education materials, tools, counseling, group visits, etc.) be a function performed by the Care Coordination Vendors, the medical home or both?

34. What do you know about serving Medicaid clients that DHCFP should take into account when developing a medical home program?

35. Do you have general reactions to the medical home design not otherwise expressed in any of the other responses?

36. As a Care Coordination Vendor, how do you view your role in this type of program?

37. How can the Care Coordination Vendor establish relationships with the rest of their provider community? Should DHCFP require formal relationships in the form of written contracts?

38. How can community providers be aligned with Care Coordination Vendors to achieve program objectives and share in financial incentives?

39. How can Care Coordination Vendors recruit and assist providers in becoming medical homes?

40. What qualifications should a care coordinator have (i.e. nurse, social worker, etc.)?

Questions for Specialists, Hospitals, Pharmacies, Home Health Providers, Nursing Facilities and other Medical Providers

Specialists, hospitals, pharmacies, home health providers, nursing facilities and other providers could play key roles in the development and delivery of medical homes. DHCFP envisions these providers to be active participants in a medical home program. DHCFP recognizes that primary care providers cannot be responsible for coordinating all aspects of client care. Therefore, in order to be successful, all medical providers must have stake in shared goals and participate in the sharing of savings.

1. Please identify yourself or your organization. What is your current relationship with the Medicaid program?

2. How could members of the provider community come together to form partnerships to create a collaborative delivery system?

3. What type of technical assistance would be needed to support community providers in forming partnerships and negotiating active roles with other providers and medical homes?

4. As a community medical provider, what is your level of interest in participating with a medical homes program? How do you view your role in this relationship?

5. How can community providers be aligned with a medical homes program to achieve program objectives and share in financial incentives?

DHCFP recognizes that physicians and primary care providers collectively deliver a small portion of services financed by Medicaid. Hospitals, pharmacy, home health, nursing homes, DME, counties and countless providers deliver care and collaborate with each other to coordinate activities to maximize the health of clients. The Care Coordination Vendor would be charged with developing coordinated efforts to ensure seamless, efficient and effective care.

6. What kind of coordination should DHCFP require the Care Coordination Vendor to perform with you and your programs?

7. Are there coordinating functions that DHCFP should withhold from the Care Coordination Vendor so that you can do these functions without additional encumbrance?

8. How can the Care Coordination Vendor help you to perform your functions better?

10. There are a variety of types of primary care providers in Nevada, including: FQHCs, rural health clinics, and private practice providers. In order to successfully provide access to all Medicaid clients, all of these provider types need to work collaboratively and cooperatively. What systems or mechanisms would need to be implemented to assure optimal cooperation and minimal financial competition between the various provider groups and systems?

11. What restrictions, if any, are there that limit your ability to share information with other entities (federal regulations, state law, board restrictions bylaws, restrictions by funders, etc.)? Can these restrictions be overcome if the patient consents to the exchange?

DHCFP is interested in maximizing the health, functioning and self-sufficiency of all patients, as well as assuring that patients receive good health care when they are sick. Physical and mental health assessments are one way to measure a patient's health status. Metrics related to healthy lifestyles and risk factors include obesity rates, smoking rates, drug and alcohol abuse rates, physical activity, binge drinking rates and others.

12. What are health and risk factor metrics would you suggest DHCFP should include in a medical home program?

13. DHCFP recognizes the role community health educators have made in improving the health of vulnerable populations; are there existing services that could be coordinated through this initiative that would promote these activities for Medicaid clients?

14. What services do regional public health offices provide that could be coordinated or supported through the medical homes to promote client health?

15. What else would you like to see addressed?

Questions for All Interested Participants

1. Please identify yourself and any organization you represent. What is your current relationship to the Medicaid program?

2. What definition should DHCFP use for a medical home (i.e. Joint Principles or something else)? What kinds of providers should qualify as a medical home (i.e. primary care providers, specialists, behavioral treatment specialists, etc)?

3. How should DHCFP recognize different tiers of medical homes (i.e. should DHCFP use the Physician Practice Connections – Patient Centered Medical Home tool or something else)?

4. What medical home model would be most effective in Nevada (partnering with other payers in statewide collaborative, hiring state-employed care coordinators, contracting with an outside care coordination vendor, or developing regional networks)? Or, is there another model that would be more effective? If so, please provide details.

5. Are there organizations or services that should be recommended to DHCFP and/or a Care Coordination Vendor to assist in implementing a medical home?

6. Would a 24/7 nurse advice line be a useful tool or would it be unnecessary?

7. The literature on value-based purchasing indicates that in order to incentivize changes at the provider level, a significant portion of the provider's patient panel must be

subject to the incentive. How can DHCFP align the Medical Homes Program with similar efforts from other payers?

8. What needs to be changed or remedied with Medicaid processes or procedures before the medical homes program is instituted?

9. In what way(s) will the creation of a medical homes program create duplication of efforts and how can duplication of efforts and services be avoided?

10. How can DHCFP ensure that all appropriate current effective community-based organizations are appropriately included in the planning and development process?

11. What steps can a medical home take to reduce avoidable hospitalizations and improve health outcomes for their patients?

12. How can DHCFP measure the success of a medical home program? What evaluation measures or tools should be used?

13. How can DHCFP help patients comply with treatment plans?

14. How should care coordination work? Should the assignment of care coordinators be based on the provider or the patient (meaning, should the care coordinator be assigned to specific providers or to specific patients)?

15. Given that only certain groups of patients would be eligible for the initial medical home program, how can DHCFP and/or providers make the identification process easy at the practice sites?

16. What would you do if you had sufficient technical and financial support and money was not a barrier? What would be the ideal program?

Other Designs

1. Is there a different health care program design that could produce similar or greater cost savings for the Medicaid population that is superior to the ones described herein? Please describe this program. What is the reimbursement structure? What is the time period? How will health outcomes be improved?

Cost

1. Please describe your estimated requirements for a PMPM Administrative Fee.

2. If a Care Coordination Vendor were to be utilized, DHCFP would need to establish mechanisms to ensure communication and collaboration between the medical home and the care coordinator. One method DHCFP is exploring is paying providers to participate in care coordination conferences on individual patients with a Care Coordination Vendor, up to four conferences per year per patient. What should the

reimbursement rates be for this? Are there other reimbursement incentives that could increase this communication? Please describe.

3. DHCFP is looking at withholding a certain percentage of the PMPM paid to the medical home and/or Care Coordination Vendor to be paid contingent on their performance on a series of quality and/or cost measures. What should this percentage be? Are there other financial mechanisms that produce shared responsibility for quality of care and expenditures? Please describe. What quality and/or cost measures should be tied to these amounts?

4. DHCFP is exploring methods for providing bonuses to medical homes for exceptional achievements on quality standards. How should this be implemented? What amount would you consider appropriate, perhaps on a quarterly or yearly basis? What financial incentives should medical homes receive for meeting or exceeding quality measures? What financial penalties should medical homes receive for falling below quality measures?

5. If the costs of programming a variable PMPM administrative fee are too great for DHCFP to incur, would the Care Coordination Vendor be willing to assume the PMPM payment function to the medical homes, using the variable rates, and be paid by a single remittance from DHCFP?

6. There appears to be a variety of challenges in determining cost savings for these types of programs. What mechanisms or processes should be used to evaluate the effect of a medical home program have on expenditures?

2.5 Submittal Instructions

The Division of Health Care Financing and Policy will accept questions and/or comments in writing, received by e-mail, regarding this RFI as follows:

Questions should reference the identifying RFI number and be addressed to DHCFP, Attn: Jennifer Benedict, e-mailed to jennifer.benedict@dhcfp.nv.gov or faxed to (775) 684-3720. The deadline for submitting questions is March 5, 2010 at 2:00 p.m. Pacific Time.

All questions and/or comments will be posted anonymously with their corresponding answers as an Amendment at http://dhcfp.nv.gov/ on the State of Nevada Division of Health Care Policy and Financing website on or about March 15, 2010 at 2:00 p.m. PST. DHCFP encourages responders to include their company name, address, phone number, e-mail address, fax number, and contact person when submitting questions, but it is not required.

2.6 Timeline

TASK	*DATE/TIME*
Release date	February 11, 2010
Deadline for submitting questions	March 5, 2010 @ 2:00 p.m. PST.
Answers to all questions available on or about	March 15, 2010 @ 2:00 p.m. PST.
RFI response due no later than	April 5, 2010 @ 2:00 p.m. PST.

NOTE: These dates represent a tentative schedule of events. The State reserves the right to modify these dates at any time, with appropriate notice to prospective vendors.

2.7 Proposal Submission Requirements:

Proposals may be submitted either electronically or through the mail. When mailing the proposals, respondents are encouraged to include a disc containing the proposal, though that is not required.

Please clearly mark the e-mail or package as:

Response to RFI No. ME79
For: Medical Homes Collaborative

Proposal should be received at the address referenced below no later than 2:00 p.m. Pacific Time, on April 5, 2010. Responses that do not arrive by proposal opening time and date may not be considered in the development of this project. Vendors may submit their proposal any time prior to the above stated deadline.

Response should be submitted to:

Division of Health Care Financing and Policy
Jennifer Benedict, Management Analyst II
1000 East William Street, Suite 118
Carson City, NV 89701

Or, electronically at: jennifer.benedict@dhcfp.nv.gov

Thank you for your interest and response to this Request for Information.

THIS IS A REQUEST FOR INFORMATION (RFI) ONLY AND IS NOT A FORMAL SOLICITATION. NO AWARD WILL RESULT FROM THIS RFI.